

FOR THE DISTRICT OF OREGON

OREGON ADVOCACY CENTER,
et al.,

Plaintiffs,

V.

BOBBY MINK, et al.,

Defendants.

JAROD BOWMAN, et al.,

Plaintiffs,

V.

DELORES MATTEUCCI, et al.,

Defendants.

LEGACY HEALTH SYSTEM, et al.,

Plaintiffs,

V.

PATRICK ALLEN,

Defendant .

Case No. 3:02-cv-00339-MO

Case No. 3:21-cv-01637-MO

Case No. 6:22-cv-01460-MO

April 25, 2023

Portland, Oregon

Oral Argument

TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE MICHAEL W. MOSMAN

UNITED STATES DISTRICT COURT SENIOR JUDGE

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1 ALSO PRESENT: Dr. Debra Pinals (by telephone)

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(P R O C E E D I N G S)

(April 25, 2023; 1:08 p.m.)

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THE COURTROOM DEPUTY: We are here today for oral argument in Case No. 3:02-cv-339-MO, Oregon Advocacy Center, et al. versus Mink, et al., Member Case Nos. 3:21-cv-1637-MO, and 6:22-cv-1460-MO.

Counsel, please state your name for the record.

MR. STENSON: Your Honor, Tom Stenson, Disability Rights Oregon.

MR. MERRITHEW: Jesse Merrithew on behalf of Metropolitan Public Defender.

MR. JOHNSON: Craig Johnson with Department of Justice for defendant.

MS. SCOTT: Carla Scott with the Department of Justice for defendants.

MR. VAN RYSSELBERGHE: Alex Van Rysselberghe with Stoel Rives for plaintiff health systems.

MR. NEIMAN: Eric Neiman for plaintiff health systems, Your Honor.

THE COURT: Thank you.

Give me just a moment. Give me just a minute here. To quote George Washington, it seems I've gone not only gray but blind in the service of my country. So I need my reading glasses.

1 (There is a pause in the proceedings.)

2 THE COURT: I thought it might be helpful to give you
3 some tentative thoughts and then we can walk through your
4 arguments about those after I'm done. And I'll break them out.
5 I won't follow chronologically through the claims by number but
6 in groups.

7 But first I want to discuss the motion to dismiss
8 what I'll call health systems' claims on behalf of health
9 systems. And the first major issue with regard to that motion
10 has to do with standing. The parties agree on the general
11 standard for standing. It's the fairly traceable prong that's
12 the most important to me, and the argument is that it's not
13 fairly traceable because the hospitals, the health systems have
14 voluntarily entered into this arrangement. And, of course,
15 it's almost always the case that if you voluntarily entered
16 into an arrangement like this, that you can't -- you don't have
17 a complaint for standing purposes. Numerous cases so hold.

18 So the real question is maybe a framing question to
19 think about voluntariness here or is it voluntary. I don't
20 know, for example -- I'm told without real debate that it's
21 voluntary to enter into this arrangement, but I don't know if
22 that's got what I'll call the Hotel California problem, where
23 you can get in but you can't get out. If that's the case, then
24 I would acknowledge that if you voluntarily entered into a
25 business relationship that you are obligated to stay in for X

1 years, and during those years things dramatically change so it
2 wasn't the deal you got into in the first place, you might have
3 standing in a case like that. But it looks like these are
4 two-year arrangements, and the complaint is that this has been
5 bad since 2017, so it looks like that's been reupped
6 voluntarily during the pendency of the time in which the
7 complaint says things are bad, and it looks like a standing
8 problem because of voluntariness. So standing is one question.

9 If there is standing, then I'll look at the claims
10 individually under 12(b)(6), and the first is the substantive
11 due process claim. That's claim 2. And there the standard is
12 whether the governmental action relates -- related to the use
13 of the plaintiff's property lacks any substantial relation to
14 the public health, safety, or general welfare.

15 And it appears to me that the governmental action is
16 the use of health systems' hospital beds for long-term care for
17 civilly committed patients. So it can't merely be that this
18 governmental action has to be imperfect, it has to lack any
19 substantial relation to public health. And I have trouble with
20 that as a description of what's happening here. It appears to
21 have some substantial relation to public health. But, again,
22 tentative only are those thoughts.

23 There's also a procedural due process component to
24 claim 2, but that has not been backed up by any argument, and
25 so it appears to be waived.

1 There's a Fifth Amendment takings claim. That's
2 claim 3. It looks a lot like the substantive due process claim
3 in some ways. The argument is a physical taking, a physical
4 taking of the beds, as I understand it, and so I don't know --
5 I don't know what will happen with the voluntariness issue, but
6 it comes up again in this setting.

7 So I suppose if there's no voluntariness for standing
8 purposes, I might be persuaded that there's no voluntariness
9 here, but it looks like you can't get the physical taking
10 because of the voluntariness issue.

11 This case hasn't been pled or argued as a regulatory
12 taking, so I'm only treating it under the physical taking
13 analysis. And the Oregon Constitution taking, the claim 4,
14 will stand or fall pretty much on the federal analysis.

15 So those are health care systems' claims on behalf of
16 health systems.

17 Now I want to look at the health systems' claims on
18 behalf of patients. Here again, issue number one is standing,
19 if health systems has to show injury in fact to health systems
20 in order to bring a claim on behalf of a third party. But if
21 we get past that, then I have to look at whether there's a
22 close relationship to the third party, which is -- turns out to
23 be, as it's litigated across cases, a sort of a correlation of
24 interests as opposed to divergence of interests. And that's
25 tough here because quite a few of the arguments made in other

1 settings by health systems are that these patients are a
2 headache, that they cost them a lot of money, that they result
3 in the attrition of staff, that they destroy property, and that
4 they don't want to do this. And that starts not to sound like
5 a correspondence of interests such that they could bring a
6 claim on behalf of a third party.

7 And then finally, when I look at the prong as to
8 whether the third parties -- here the patients -- are hindered
9 by their mental illness in advancing their claims on their own,
10 well, that's again a mix. Obviously the answer is yes, yes for
11 the reasons that maybe any indigent patient or other -- even
12 any patient might be hindered in bringing a claim on its own
13 because of illness. But almost by definition, some of these
14 folks -- Well, let's put it this way. In a criminal case,
15 they're disentitled, disenfranchised from making decisions on
16 their own. So I don't know how they could bring a lawsuit.
17 But I say a mix because, on the other hand, there's this lack
18 of coalition of interests, and I have right in front of me an
19 organization whose mission is dedicated to bringing claims on
20 behalf of people like this. So why wouldn't I pick DRO rather
21 than health systems to advance these claims? So that's the
22 standing issue.

23 If I turn to 12(b)(6) and get past all that, then the
24 substantive due process claim is again a question of adequate
25 and effective treatment. And that, as a pleading matter, in my

1 view, may survive, given that that's what we're litigating
2 generally.

3 There's again no argument on the procedural due
4 process claim. The Oregon statutory claims 5 and 6, in
5 particular, seem to me to devote the decision entirely to OHA,
6 whose decision shall be final, which is read in many settings
7 where that sort of language is used as nonreviewable. So
8 that's a concern.

9 Claim 7 has a problem, in that it has to be -- is
10 grounded in denying patients treatment or limiting them because
11 of some disability, and that doesn't appear to be the
12 foundation for the treatment decisions made here, since the
13 entire set is identical in that way and a subset is being sent
14 to health systems.

15 There is this motion for clarification on
16 intervention, but let's start then, since it runs through all
17 the claims, the claims themselves and both pieces of the motion
18 to dismiss, let's start with standing, again with counsel for
19 health systems.

20 Can I just put the first question to you, just --

21 MR. VAN RYSSELBERGHE: Yes.

22 THE COURT: Why isn't this relationship voluntary?

23 MR. VAN RYSSELBERGHE: So the relationship, the
24 voluntariness of the relationship, you can look at it in, I
25 think, two ways. And Your Honor has brought up the way of

1 looking at it across a timeline. I think it is not voluntary
2 if you look at it across even from '17, 2017 until now. There
3 have been changes and just the worsening of Oregon's behavioral
4 health crisis over that time. So it absolutely is one of those
5 cases -- and I think we allege this in the complaint
6 sufficiently -- that even the changes of -- in the Oregon State
7 Hospital admissions and the decreasing resources outside the
8 Oregon State Hospital for long-term treatment options has been
9 changing over that period of time, such that the agreement that
10 was made in '17 has to be reconsidered at this point, and that
11 there's no voluntariness now there.

12 THE COURT: If you really reach the point where you
13 really hated this arrangement -- which you're apparently close
14 to doing -- could you leave the arrangement? Could you cease
15 being designated as a facility that would receive these folks?

16 MR. VAN RYSSELBERGHE: So I think it's important to
17 distinguish the kinds of treatment we're talking about here.
18 There's the long-term treatment, which is what we cannot
19 provide, and then there's the acute stabilizing treatment that
20 we do and want to continue providing.

21 Now, I suppose that if signing up for the former kind
22 of treatment, which is materially different, automatically
23 signed us up to provide the latter, which we simply cannot
24 provide, then in that case we could withdraw from the
25 arrangement entirely. But that's to conflate these two kinds

1 of treatment that our allegations in the complaint distinguish.

2 THE COURT: Well, before I move further down that
3 path, I want to be clear then. You are in some sort of
4 arrangement that initially, in your view, involved receiving
5 from the State Hospital patients you did want to treat?

6 MR. VAN RYSSELBERGHE: Correct.

7 THE COURT: And you did -- This is a question now.
8 You did enter voluntarily into a sort of a contract
9 relationship to receive those patients, right?

10 MR. VAN RYSSELBERGHE: So I would dispute that it's a
11 contractual relationship.

12 THE COURT: You did enter into some sort of
13 arrangement that was voluntary. That is, you didn't have to do
14 it as a business?

15 MR. VAN RYSSELBERGHE: We voluntarily sought
16 certification to provide, importantly, acute care or the
17 five-day hold kind of treatment.

18 THE COURT: Let's just stick with acute care. And so
19 you voluntarily entered into an arrangement to provide acute
20 care, and not every health system in the state of Oregon did
21 that, correct?

22 MR. VAN RYSSELBERGHE: It's my understanding, yes.

23 THE COURT: And you could tomorrow quit providing
24 acute care if you decided it didn't fit your mission anymore,
25 you didn't want to do it?

1 MR. VAN RYSSELBERGHE: I believe that is correct.

2 THE COURT: So, as I understand it, you want to make
3 distinction -- and I'll hear you out on that -- between the
4 kind of care you said you agreed to provide and the kind of
5 care you're being asked to provide now. But in terms of the
6 arrangement for acute care, it's voluntary, right?

7 MR. VAN RYSSELBERGHE: The arrangement for
8 specifically acute care and the five-day hold is voluntary.

9 THE COURT: And if that acute care arrangement has
10 morphed into something you dislike for a variety of reasons --
11 one, that you say you cannot do it; and two, because you don't
12 have the beds to even do it, or any other reason -- if it
13 morphs into something other than what you wanted to do when you
14 started down this path, then you could also just say, well,
15 then this isn't working for us anymore; we quit?

16 MR. VAN RYSSELBERGHE: So to the extent that the
17 nature of acute care --

18 THE COURT: I want to hear you out on this, I really
19 do. But first I want a yes-no answer if that's possible. If
20 it's not, then just tell me. But could you quit?

21 MR. VAN RYSSELBERGHE: Yes.

22 THE COURT: Go ahead and finish your answer.

23 MR. VAN RYSSELBERGHE: Okay. So I think to say that
24 acute care has morphed into something different, that's not
25 what we allege in the complaint. We're distinguishing acute

1 care as one particular kind of treatment as opposed to
2 long-term care. And so this is not a question of whether acute
3 care has morphed, it's that we've signed up to provide acute
4 care and stabilizing care, and now as a result of us signing up
5 for that kind of care, we are being forced to provide the
6 latter type of care -- long-term treatment -- which we have not
7 voluntarily agreed to provide.

8 And I think you can see this in the certificates that
9 health systems have provided in our motion for judicial notice.
10 If you look at the checkmarks that we have checked in that --
11 in the various forms, there's distinguishing, you know --
12 there's acute care options that you can check, there are
13 five-day hold options you can check. Those are the boxes we
14 checked. Now, there's also secure residential treatment care,
15 which is long-term care, we continue that, but the Class 1 and
16 2 variety, none of the health systems checked that box. And so
17 there is absolutely a situation that we have alleged in our
18 complaint that's consistent with those forms in which we have
19 been signed up to provide one type of care and now we are being
20 required, and sort of OHA is outsourcing to us this latter type
21 of care that was never part of our voluntary arrangement. And
22 that's why we have not voluntarily -- we've not voluntarily
23 taken on this interim level.

24 THE COURT: Why haven't you told OHA that you refuse?

25 MR. VAN RYSSELBERGHE: We have. And the reason that

1 nothing has happened is because there's nowhere for these
2 patients to go after the point where we cannot medically do
3 anything for them further, and Oregon law prohibits us from
4 discharging patients in this situation unless they have a place
5 to go, provided that they are still in need of medical
6 treatment, which these classifications are.

7 THE COURT: Thank you.

8 MR. VAN RYSSELBERGHE: Thank you.

9 So unless Your Honor has further questions --

10 THE COURT: That's your core argument on
11 voluntariness, right?

12 MR. VAN RYSSELBERGHE: That's correct.

13 THE COURT: Thank you. I'll probably come back to
14 you.

15 MR. VAN RYSSELBERGHE: Thank you.

16 THE COURT: Your response, Ms. Scott?

17 MS. SCOTT: So plaintiffs allege that OHA is forcing
18 or requiring them to treat civilly committed patients on a
19 long-term basis, but they don't cite any law that shows they
20 are, in fact, required or forced to treat civilly committed
21 patients on a long-term basis. The Oregon Administrative Rules
22 provide to the contrary, that county mental health providers
23 have delegated authority to assign civilly committed patients
24 to appropriate facilities, that the receiving facility must
25 have space and consent to the placement. That is in OAR

1 309-033-0420.

2 We don't see anything in the complaint in which
3 private hospitals are forced to treat these patients. There
4 are no allegations that the hospitals have asked OHA for
5 additional funding or that OHA has declined any request for
6 additional funding to treat these patients.

7 So I think counsel said it pretty simply just now.
8 They could quit. So that, I think, means they have voluntarily
9 assumed care for these patients on a long-term basis. So I
10 think that is a fatal problem for their standing.

11 THE COURT: He says they told the hospital that they,
12 in essence, refused to receive these patients and nothing
13 changes. Why is that?

14 MS. SCOTT: I haven't seen that allegation in the
15 amended complaint.

16 THE COURT: What about the allegation that is in the
17 complaint, that they can't turn away people who show up on an
18 emergency basis?

19 MS. SCOTT: I heard counsel say they cannot turn away
20 patients if they need medical treatment. I didn't hear him
21 cite the statute. I would be prepared to look at that and
22 answer that. But the OAR does require their consent to admit a
23 civilly committed patient. And so that is a separate
24 consensual status, in addition to the certifications that they
25 applied for and obtained.

1 THE COURT: And the certification is an additional
2 indicia of voluntariness, in your view?

3 MS. SCOTT: It is.

4 THE COURT: And that occurs every two years?

5 MS. SCOTT: I believe so. I'm not an expert on that,
6 but I think the applications are in the record and the
7 certifications.

8 THE COURT: All right. Thank you very much.

9 Do you wish to reply?

10 MR. VAN RYSSELBERGHE: I would. Thank you.

11 THE COURT: Why don't you read your note from
12 Mr. Johnson.

13 MR. VAN RYSSELBERGHE: If necessary.

14 THE COURT: (To Mr. Johnson) You're welcome to sit up
15 here if you like. Did you not iron your shirt today?

16 MR. VAN RYSSELBERGHE: All right. So I have a couple
17 of points I'd like to respond to here.

18 So first of all, I'd just like to revise my earlier
19 note about how we can't quit and whether we can or can't. So I
20 should point out that we do have emergency departments, and by
21 nature of having an emergency department, that's not the same
22 thing as an acute care inpatient facility. And so to the
23 extent we have emergency departments, we absolutely cannot
24 quit. And since some of our patients come in through that
25 doorway, we cannot stop providing services to those patients.

1 THE COURT: When you say some of your patients come
2 in through that doorway, you mean just generally from the
3 community or do you mean some of these patients on whom you're
4 seeking to litigate?

5 MR. VAN RYSSELBERGHE: So -- both.

6 THE COURT: Do you receive patients from OHA through
7 ER?

8 MR. VAN RYSSELBERGHE: Yes.

9 THE COURT: Civilly committed patients?

10 MR. VAN RYSSELBERGHE: So they will not generally be
11 civilly committed at the point of entry, but they will become
12 civilly committed in our care.

13 THE COURT: But otherwise the sort of patients that
14 we've been talking about who release to your care, they don't
15 arrive through the ER, do they?

16 MR. VAN RYSSELBERGHE: Some of them arrive through
17 the ER, and others arrive into Unity Hospital, for instance,
18 which has an emergency department and otherwise.

19 THE COURT: But the requirement that you admit
20 someone to the ER, that's separate from the voluntariness issue
21 we're discussing today, isn't it?

22 MR. VAN RYSSELBERGHE: It's not, because we have to
23 treat and evaluate every patient who walks through our door,
24 regardless of their ability to pay.

25 THE COURT: Again, you've suggested that we be a

1 little bit more precise about that. Not every patient who
2 walks through your door. Every patient who walks through your
3 ER, right?

4 MR. VAN RYSSELBERGHE: We have to treat -- we have to
5 evaluate and treat, if needed, every patient who walks through
6 our ER doors or the doors to our acute facilities, acute care
7 facilities. That's under EMTALA. It's a federal statutory and
8 regulatory regime that requires us to treat everyone and
9 evaluate everyone regardless of their ability to pay. And
10 so -- and that makes us kind of like the *Doe v. Shibinette*
11 case, where New Hampshire law requires hospitals in that state
12 to accept everyone who comes through the door, which is the
13 basis of the Supreme Court, district court, and First Circuit's
14 rejection of this argument that nothing is forcing those
15 hospitals to provide treatment.

16 So I think it might help to just walk through here
17 the track of a patient. But before I do that, I just wanted to
18 just address the points counsel made. So it is in the
19 complaint that we pleaded with OHA. It's in paragraph 46,
20 where we've said that we have tried to address these issues
21 with OHA for years and there's been no results.

22 And regarding the statutes that require us to
23 continue to house patients who no longer are medically
24 benefiting from our acute care and stabilizing services, that
25 would be ORS 441.053 and 054, in addition to an OHA regulation

1 OAR 333-505-0055. Those laws require --

2 THE COURT: I'll pause you there. I'm concerned
3 you're starting to shove your private note up onto the screen.
4 I'd like you not to do that.

5 MR. VAN RYSSELBERGHE: I apologize, Your Honor.

6 THE COURT: So what do those say?

7 MR. VAN RYSSELBERGHE: What does what?

8 THE COURT: What do those regulations and statutes
9 say?

10 MR. VAN RYSSELBERGHE: So those regulations say that
11 when a patient is receiving behavioral health treatment from
12 our hospitals, we cannot discharge them unless it was in
13 accordance with a created discharge policy and plan that
14 considers the individual needs of our patients. And so if our
15 doctors have determined that our patients need further
16 treatment, but that treatment cannot be provided in our
17 hospitals but there's nowhere for those patients to go outside
18 of our hospitals, those patients get stuck in sort of this
19 limbo where they can't go elsewhere, they can't be discharged
20 to the sidewalk, and so -- but we can't really do anything
21 medically. We can't provide them the long-term treatment that
22 they need medically. And so that's the kinds of patients that
23 we're talking about here.

24 THE COURT: So on voluntariness, let's assume it goes
25 like this, that OHA sends you a patient and it's really not for

1 acute care or it long outlasts acute care into the sort of
2 long-term care that you say you're not equipped to provide. So
3 you call up OHA and you say, "We don't think we should have
4 this patient. You shouldn't have sent this patient here in the
5 first place," and OHA says -- I know it's not what's happening,
6 so that's why it's a hypothetical.

7 OHA says, "You're right, that patient shouldn't be
8 there." And then by operation of these other principles and
9 laws, you realize you can't discharge the patient.

10 Is that laid at the feet of OHA making your continued
11 care for that patient involuntary or is that separate from OHA
12 because it is statutes on the books drafted by the legislature?

13 MR. VAN RYSSELBERGHE: So please correct me if I'm
14 misunderstanding your question. We do allege that the buck
15 ultimately stops with OHA to ensure that long-term treatment is
16 provided to these civilly --

17 THE COURT: I can phrase it more simply, I guess. If
18 OHA says, "We don't need you to keep these patients anymore,"
19 but you keep them anyway because of what you've just described,
20 that you decide that they still need care and there's no place
21 else for them to go, does that make OHA's and your problem
22 involuntary by you, or does OHA's decision to go ahead and let
23 you bow out make it something else?

24 MR. VAN RYSSELBERGHE: So, again, I apologize --

25 THE COURT: What I'm asking is if it's Oregon

1 legislative enactments that make you keep this patient --

2 MR. VAN RYSSELBERGHE: Yes.

3 THE COURT: -- and not your arrangement with OHA. I
4 recognize it's all the State of Oregon, so that's my question.
5 Are you in the same position, it doesn't matter whether OHA is
6 making you keep them or state legislative enactments are making
7 you keep them? Is it all the same to you?

8 MR. VAN RYSSELBERGHE: It's the state legislative
9 enactments that are making us keep these patients. It's also
10 OHA's regulations. It's both of those. If OHA were to
11 decide -- I don't think that they are truly taking the position
12 that we should be discharging patients who are in need of care
13 to the sidewalk despite their needs, despite the fact that
14 they're still a danger to themselves and others and unable to
15 care for the basic needs. Even if they were to take that
16 position and say just discharge them, we would still be
17 obligated to follow Oregon statute, which OHA can't override.
18 We would have to also follow EMTALA. So there's several
19 provisions at play here, including but not limited to OHA's
20 regulations and directives.

21 THE COURT: One of them you mentioned was federal
22 law, right?

23 MR. VAN RYSSELBERGHE: Correct.

24 THE COURT: That, of course, can't be laid at the
25 feet of the State, right?

1 MR. VAN RYSSELBERGHE: Repeat, please.

2 THE COURT: That, of course, cannot be laid at the
3 feet of the State in any way, right?

4 MR. VAN RYSSELBERGHE: I think not literally, no, but
5 effectively --

6 THE COURT: Well, literally it can't be laid at their
7 feet in any way, because it's a metaphor, that's true.

8 MR. VAN RYSSELBERGHE: It can't be directly -- so
9 that is an operation of federal law, but that is, you know,
10 when you're talking about voluntariness, we're talking about
11 the overall framework, which includes state law, federal law,
12 and regulatory provisions. And so the -- just the fact that
13 it's a federal law does not somehow absolve OHA of its
14 statutory obligation to civilly committed patients.

15 THE COURT: Well, I'm just looking at whether you're
16 suffering a harm that you could cease suffering by your own
17 actions. That's the standing question. So I'm not looking at
18 a big framework. I'm just looking at do you have a way out
19 where you could quit suffering this harm. So if you have a way
20 out and you keep suffering the harm, then you don't have
21 standing to complain. And you're saying -- you've essentially
22 told me today you don't have a way out.

23 MR. VAN RYSSELBERGHE: We're saying we don't have a
24 way out. Again, going back to the fact that we have to accept
25 patients through our emergency department, and that is not

1 something that is subject to our certification as a voluntary
2 participation in providing involuntary treatment.

3 THE COURT: Well, I guess it just strikes me even
4 from your complaint that the path to your client health systems
5 isn't typically through the ER. Am I wrong about that?

6 MR. VAN RYSSELBERGHE: It happens. I don't have the
7 numbers or the proportions about how many come through ER
8 versus into acute inpatient facilities directly, but it's a
9 mix, and we're talking about both avenues here.

10 THE COURT: And I guess I thought you were saying a
11 minute ago that it really doesn't matter which it is, that one
12 way or another, you cannot discharge these patients.

13 MR. VAN RYSSELBERGHE: So our position is that it
14 doesn't matter to the extent that you find the voluntariness
15 component of the acute care provision, if that, you think, is
16 voluntary, we can avoid that. That doesn't change the fact
17 that the emergency room situation is what it is, and that's not
18 voluntary.

19 THE COURT: All right.

20 MR. VAN RYSSELBERGHE: Now, we -- with the acute
21 care, we contend that that's still not voluntary because we
22 have a right to provide the kind of treatment that we go into
23 business to provide, which in our case is acute care and
24 stabilizing treatment.

25 THE COURT: You have a right to provide acute care to

1 these patients?

2 MR. VAN RYSSELBERGHE: What I mean by that is to say
3 that in the same way that, you know, a doctor specializes in a
4 certain kind of care, you don't fault the doctor for not
5 providing every type of care in the universe, and we can go --
6 we provide one type of care that doesn't require us to provide
7 every type of care, every type of behavioral health care that
8 exists.

9 THE COURT: I understand that.

10 MR. NEIMAN: Judge Mosman, I'm here to talk about the
11 merits after the standing issue is addressed, but I can speak
12 to the pathways that the patients follow.

13 THE COURT: Go ahead.

14 MR. NEIMAN: So first of all, these -- sorry.

15 THE COURT: You can be seated. That's fine.

16 MR. NEIMAN: First of all, these patients do not come
17 to the hospitals we represent through OHA, nor are they
18 generally discharged from Oregon State Hospital to our
19 hospitals. These are people who are in the community who
20 decompensate psychiatrically, brought usually by law
21 enforcement, sometimes by family, sometimes by public officials
22 to our hospital emergency departments. And there are about
23 7,000 of them, more than 7,000 every year.

24 Once they reach the emergency department, EMTALA
25 takes over, and the hospital emergency departments have to

1 evaluate the patients by what's called a medical screening exam
2 for any kind of condition, including a psychiatric condition,
3 which is specifically covered by federal law. If that patient
4 is psychiatrically unstable and dangerous to self or others as
5 part of that definition, that patient cannot be discharged
6 without violating federal law. And that happens, as I said,
7 across the state more than 7,000 times a year.

8 At that point, what the State is not recognizing is
9 when a notice of mental illness, initiating a bed of a civil
10 commitment proceeding is placed, that patient is no longer just
11 a hospital patient. That patient is within the State's mental
12 health system. It's the responsibility of the State. And the
13 core of our complaint is that at that point in time when those
14 7,000 people who are detained pursuant to the civil commitment
15 laws are kept in the hospital involuntarily every year, at that
16 point they cannot be released, and it's the State's
17 responsibility to move forward with civil commitment
18 proceedings to determine whether they meet the statutory
19 standards.

20 THE COURT: And the core of your complaint is that
21 that doesn't happen and you keep them?

22 MR. NEIMAN: Correct.

23 THE COURT: If I understand you correctly so far, the
24 ER is really -- predates, at least if it predates civil
25 commitment, it predates the complaint that you have with the

1 State here?

2 MR. NEIMAN: In the emergency department, for the
3 patients who meet detention criteria, a notice of mental
4 illness is placed.

5 THE COURT: You told me that. What I'm asking is
6 doesn't all of that predate typically by at least a few hours,
7 if not a few days, civil commitment?

8 MR. NEIMAN: Yes.

9 THE COURT: And it's upon civil commitment that you
10 have the complaint in front of me that says the State should be
11 taking over here and they're not. They're making you keep
12 these patients, right?

13 MR. NEIMAN: Well, no. Because for many of those
14 patients, our hospitals welcome the opportunity to --

15 THE COURT: Sure. But at some point that's the
16 population from which you get the patients that form the
17 gravamen of this complaint, right?

18 MR. NEIMAN: Right. At some point --

19 THE COURT: My only question was then the ER doorway
20 that we've described really predates any relationship that you
21 have, arrangement, certification, or voluntariness with OHA,
22 right?

23 MR. NEIMAN: Except for the fact that we're licensed
24 as hospitals. As soon as somebody is detained by way of a
25 notice of mental illness, there's a set of administrative

1 rules.

2 THE COURT: All sorts of people arrive at your ER,
3 and some of them later are going to become the patients who
4 form the subject of this complaint and some won't, right?

5 MR. NEIMAN: Correct.

6 THE COURT: And for those first few days, we don't
7 know what's going to happen yet until they become civilly
8 committed, right?

9 MR. NEIMAN: That's right.

10 THE COURT: So until they become civilly committed,
11 your complaint -- this complaint -- doesn't really apply yet,
12 right?

13 MR. NEIMAN: Right. Our complaint is directed to the
14 smaller group of people who are civilly committed after a
15 hearing and who have reached the point where they're no longer
16 benefiting from being in the hospital.

17 THE COURT: That's very helpful. Thank you.

18 But I guess the follow-up question I have is then the
19 voluntariness or not of people who show up at your ER is a
20 different subject than the subject matter of this complaint,
21 because it applies to a whole set of people who may or may not
22 end up in this complaint, right?

23 MR. NEIMAN: There's a complicated answer to that
24 simple question having to do with possible alternative places
25 for people to go besides emergency departments, but the answer

1 to what you're asking is, the period of time before the civil
2 commitment order is entered is not part of our complaint. It's
3 part of the flow of events that leads to our complaint.

4 THE COURT: Sure. All right. Thank you very much.

5 MR. NEIMAN: And then I wonder if the Court has any
6 questions about -- any more questions about the hospital's
7 ability to discharge people legally once they've reached the
8 point where the hospital can't provide any more care to them
9 that's going to benefit them, because that's what our case is
10 about.

11 THE COURT: So I've heard your colleague's
12 explanation. Do you wish to amplify it?

13 MR. NEIMAN: Not unless the Court has any questions.
14 I thought he did a great job.

15 THE COURT: Thank you. No, I don't.

16 Ms. Scott.

17 MS. SCOTT: I don't have anything further unless the
18 Court has specific questions.

19 THE COURT: So I do. On voluntariness, then, at the
20 risk of oversimplifying it, there are three, at least, time
21 periods to think about voluntariness, because what I'm asking,
22 what I'm really asking isn't so much a question of whether
23 medical care can or cannot be provided but whether the harm
24 that's alleged in this complaint can be evaded through some
25 voluntary action. And so there's multiple spots in time in

1 which the harm theoretically could be evaded. One is not to
2 enter into any certification relationship with OHA, because
3 that's voluntarily entered into, right?

4 MS. SCOTT: Correct.

5 THE COURT: And that's the core of your briefed
6 argument is that since that relationship is one that health
7 systems entered into voluntarily, they could just not do that
8 and therefore not suffer the harm. Right?

9 MS. SCOTT: That's right.

10 THE COURT: And the argument you've heard is that
11 well, that's not quite true that we could cease to be in that
12 sort of relationship but still be obligated to receive patients
13 and treat them. I guess so far my impression is that not
14 entering into this certification relationship with OHA might
15 not change the picture much as to who shows up at the hospital
16 for treatment. Do you agree?

17 MS. SCOTT: I do agree. I believe federal law is
18 what requires the private hospitals to screen in an ER setting
19 and evaluate and stabilize the patient before transferring
20 them. It does not require a private hospital to admit a
21 civilly committed or someone who may be civilly committed on a
22 long-term basis.

23 THE COURT: All right. The second point is the one
24 counsel just mentioned, and that is that at some point along
25 the way of the total number of thousands of people who show up

1 at the ER, some number of them are going to be civilly
2 committed. Right?

3 MS. SCOTT: Yes.

4 THE COURT: And then your client does step into the
5 picture in some way. Correct?

6 MS. SCOTT: OHA, once they're civilly committed,
7 OHA -- OHA is responsible for them once they are civilly
8 committed, correct.

9 THE COURT: And here we come closer to the timetable
10 you've briefed, and that is your idea is that if they're
11 civilly committed, starting with the need for acute care, you
12 are only going to send them -- or place them, rather, for
13 treatment with a facility that has entered into this
14 certification relationship with OHA. Is that correct?

15 MS. SCOTT: I think that's right. The way the
16 placement decision happens is that OHA has delegated its
17 placement authority to the county mental healthcare providers.
18 They then make a placement decision, and sometimes it is with a
19 private hospital, but the private hospital still has to consent
20 under the Oregon Administrative Rules to such a placement.

21 THE COURT: Another way to think about it is if this
22 all happened, someone showed up at the ER and then they got
23 civilly committed, and it so happens that the hospital whose ER
24 they showed up to isn't in this certification relationship,
25 then it would be either impossible or at least unlikely that

1 they'd be placed for treatment there. Is that right?

2 MS. SCOTT: It would be the hospital's choice at that
3 point what to do with the patient. There's no state law
4 forcing them to admit or not admit them at that stage.

5 THE COURT: Only federal law?

6 MS. SCOTT: Yes. And federal law only requires the
7 ER treatment. It does not require long-term admission.

8 THE COURT: And then the last stage of the timetable
9 is that they've been placed for treatment for whatever reason,
10 and the hospital's ability to provide any further acute
11 treatment has come to the end. The hospital feels that they
12 are not in a position to provide long-term care or treatment of
13 any kind for this category of patient. And here they argue
14 that a variety of laws require them, if there's no other
15 alternative, to continue to house such patients. In other
16 words, they argue that it's involuntarily now their
17 responsibility to keep these patients.

18 MS. SCOTT: The laws that I heard counsel cite all
19 involve emergent situations, emergency medical issues,
20 emergencies, not a long-term care issue. So I don't think
21 anything -- if a patient is not experiencing an emergency, then
22 there's nothing preventing a private hospital from choosing to
23 not continue the relationship.

24 THE COURT: Discharging -- so you contend that these
25 patients that are the subject of this complaint at the back

1 end, when the hospital says, our acute phase of treatment is
2 over, we didn't sign up for anything else, nor are we capable
3 of giving it, you're contending the hospitals are completely
4 free, at least under state law, to discharge these patients out
5 into the community?

6 MS. SCOTT: That's right. It's my understanding that
7 as professional treatment centers, they don't want to do that
8 because it's not the right thing to do. And the State doesn't
9 want them to do that necessarily either, but there's no legal
10 requirement preventing them from alleviating the concerns that
11 they have vis-a-vis their own financial situation with having
12 these patients in their beds.

13 THE COURT: So your voluntariness argument, not to
14 put too fine a point on it, is that they could avoid the harm
15 of continued care of these patients by doing the one thing no
16 one wants them to do?

17 MS. SCOTT: It's a tough situation to be in, but that
18 is correct.

19 THE COURT: All right. Thank you very much.

20 MR. NEIMAN: Judge Mosman, that argument reflects a
21 misinterpretation of the detailed Oregon Administrative Rules
22 that apply to the civil commitment process. Only a director of
23 a community mental health program can place an individual who
24 has been civilly committed in a certified hospital, and it is
25 incorrect to say that a hospital which has somebody admitted

1 there who is sick and unstable and under an order of civil
2 commitment can choose to discharge that person because it feels
3 like it. That violates the federal conditions of participation
4 for Medicare-participating hospitals. And I'm surprised to
5 hear that from Oregon Health Authority, which takes custody --

6 THE COURT: To be more precise about it, she was
7 careful to say that no state law requires it.

8 MR. NEIMAN: Well, the provisions of ORS Chapter 426,
9 and specifically ORS 426.060 and ORS 426.150, require the
10 Oregon Health Authority to take custody of somebody who has
11 been civilly committed, and deliver that person to a place for
12 treatment. The idea that after that delivery and while the
13 person is still civilly committed, still meets commitment
14 criteria, it's very surprising to hear from Oregon Health
15 Authority that they would endorse discharge from a hospital of
16 somebody who is under an order of civil commitment.

17 THE COURT: Fair enough. But what you've recited
18 tells me that Oregon Health Authority can never walk away from
19 its commitment to civilly committed patients, but it doesn't
20 tell me that you have a legal obligation to either accept or
21 continue to care for these patients.

22 MR. NEIMAN: Well --

23 THE COURT: Do you?

24 MR. NEIMAN: Yes.

25 THE COURT: Other than federal law?

1 MR. NEIMAN: Yes. The hospital, community hospital
2 which has a patient who is -- meets civil commitment criteria
3 and is unstable and is unsafe to leave, which is what meeting
4 civil criteria means, cannot simply discharge that person.

5 THE COURT: Ever?

6 MR. NEIMAN: Well, until they're stable or there's a
7 place to transfer them.

8 THE COURT: So not stable, never. That's your
9 position?

10 MR. NEIMAN: Correct.

11 THE COURT: That's what law requires?

12 MR. NEIMAN: That's right. As long as the individual
13 meets civil commitment criteria, a hospital which has that
14 individual as a patient can't discharge that person.

15 Now, there is a procedure for somebody to not be
16 civilly committed anymore, but that's not the group of people
17 we're talking about here.

18 THE COURT: And just so I'm clear, your position is
19 that if this whole arrangement became no longer viable for your
20 client and they chose simply to end this certification
21 relationship with OHA, that wouldn't change much?

22 MR. NEIMAN: It would not.

23 THE COURT: Because if they came in through the ER
24 and were in an acute phase and you cared for them through the
25 acute phase, there are other laws separate from the

1 certification arrangement that would require their continued
2 care unless they either were stabilized or there was some
3 community placement that was viable?

4 MR. NEIMAN: The certifications allow the hospital to
5 provide certain services to people who are civilly committed
6 over a short period of time. They -- there's nothing that
7 anyone has cited to you, nor does anything exist in the Oregon
8 Administrative Rules or anywhere else that says that the
9 certifications that our clients have accepted obligate them or
10 relate in any way to long-term care.

11 THE COURT: No, that's not my question. My question
12 is if you ended the certification relationship -- because
13 that's what your opponent's brief has suggested is a viable
14 option for you. If you don't like how this is going, then you
15 can just voluntarily withdraw from this business relationship.
16 If you did that, would you then be in a position to no longer
17 be suffering the harm you've alleged in your complaint?

18 MR. NEIMAN: Basically no.

19 THE COURT: Why not?

20 MR. NEIMAN: Because the patients would still be
21 hospital patients and they would still be part of the state
22 mental health system.

23 THE COURT: So what does the certification
24 relationship accomplish if it doesn't distinguish between
25 hospitals who have entered into it and those that don't?

1 MR. NEIMAN: It allows certain regulated services to
2 be provided, such as acute stabilization, which is one of the
3 certifications that our clients have, which --

4 THE COURT: So if someone showed up at a hospital
5 that didn't enter into this relationship and that patient
6 needed acute stabilization services but the hospital to which
7 this person arrived hadn't entered into this certification
8 relationship, what would happen to that patient?

9 MR. NEIMAN: Well, that happens all the time.

10 THE COURT: What would happen?

11 MR. NEIMAN: I can tell you generally what happens is
12 the patient is held in the hospital emergency department of
13 uncertified hospitals, and then eventually transferred to a
14 hospital that can provide the level of service that the initial
15 hospital could not.

16 THE COURT: Before you move on, why doesn't that then
17 tell me if you retreated from this certification relationship
18 that you would no longer have to receive these patients and you
19 could send them to a hospital who wished to do so?

20 MR. NEIMAN: Could I ask the Court to repeat that
21 question?

22 THE COURT: You just told me that what happens, what
23 distinguishes hospitals who have entered into this
24 certification relationship from those who don't, is that if
25 someone shows up at the ER of the hospital who hasn't entered

1 into this certification relationship, that typically that
2 patient, short or long term, eventually get transferred to a
3 hospital who has. So why wouldn't that happen to your clients
4 if they retreated, ceased being in this relationship? Why
5 wouldn't they then be at liberty, upon receiving patients like
6 this, to send them to a different hospital?

7 MR. NEIMAN: They wish to be certified to provide
8 acute care services.

9 THE COURT: Of course they wish that, but if they
10 decided that wish was costing them too much money and they got
11 out, wouldn't they then be able to send patients to a different
12 hospital?

13 MR. NEIMAN: No, because there isn't any capacity.
14 And that's what our case is about.

15 THE COURT: You just told me a minute ago that what
16 typically happens is that if a hospital isn't certified, the
17 patient that we've just been talking about gets sent to a
18 hospital that is certified. So isn't that what happens?

19 MR. NEIMAN: For the hospitals that are not
20 certified, yes.

21 THE COURT: They send them to a hospital that is?

22 MR. NEIMAN: Or the patient gets better enough in
23 that hospital to not need to be transferred.

24 THE COURT: Fair enough. So if that's what happens,
25 then why isn't it the case that if you bowed out, said we don't

1 want to be certified anymore, you wouldn't have to maintain
2 these patients over any significant period of time? You could
3 send them to a hospital that was certified.

4 MR. NEIMAN: Because what our clients want to do and
5 what they signed up to do is acute care. And for that --

6 THE COURT: I don't mean to minimize that answer,
7 because I'm grateful that you have clients like this who want
8 to do this, and there's a desperate need for it. And I'm not
9 convinced that the answer that might be -- that might be
10 required by standing doctrine is anything but a terrible
11 answer. Nevertheless, haven't you just told me that you could
12 avoid this harm by just getting out of this game entirely and
13 punting it to somebody else? I know you have told me your
14 clients don't want to do that -- God bless them for that -- but
15 couldn't they get out of this game entirely and punt the
16 problem to somebody else and avoid the harm you're suffering as
17 alleged in the complaint?

18 MR. NEIMAN: I don't think they could, Your Honor,
19 because --

20 THE COURT: Why not?

21 MR. NEIMAN: There isn't anywhere else to send the
22 patients.

23 THE COURT: The struggle I have with that answer is
24 when you answered my other question a minute ago, you said,
25 "I'm going to tell you what actually happens," and you told me

1 if the hospital is not certified, they ship their patients to
2 somebody else.

3 MR. NEIMAN: Those aren't our hospitals.

4 THE COURT: I know that. We wouldn't be here if they
5 were. Thank you for your answer.

6 Let's move on to the substance of health systems'
7 claims on behalf of health systems. The first is a substantive
8 due process claim. I don't think I need to hear more argument
9 on that one.

10 And it is correct, isn't it, that -- that's claim 2.
11 And it is correct, isn't it, that the procedural due process
12 element of claim 2 you've essentially walked away from, right?

13 MR. NEIMAN: We haven't briefed it.

14 THE COURT: All right. Fair enough.

15 So the Fifth Amendment takings claim requires me to
16 find that there's a physical taking of your beds by this
17 regulatory -- by this state action.

18 You'd agree, wouldn't you, that that issue stands or
19 falls on the same voluntariness question? If you win on
20 voluntariness on standing, then you win it on Fifth Amendment
21 taking. And if you lose it, if I find that you're -- that you
22 could voluntarily get out of this harm, then you lose the Fifth
23 Amendment takings claim as well. Right? I'm not asking about
24 the merits. I'm just asking doesn't the Fifth Amendment
25 takings claim stand or fall on voluntariness?

1 MR. NEIMAN: So the Court is talking about the
2 voluntary participation doctrine, I think.

3 THE COURT: I am.

4 MR. NEIMAN: We're actually talking about both a
5 physical and a regulatory taking.

6 THE COURT: I guess I missed the regulatory taking
7 claim.

8 MR. NEIMAN: That has to do with the Oregon
9 Administrative --

10 THE COURT: I know what it has to do with. I just
11 didn't see it in your complaint. Where is it?

12 MR. NEIMAN: It has to do --

13 THE COURT: Let's start with this. I love labels.
14 Is there a claim anywhere in this complaint that says
15 "regulatory taking"?

16 MR. NEIMAN: No.

17 THE COURT: All right. Is there any other paragraph
18 in which you claim regulatory taking?

19 MR. NEIMAN: The claim is by operation of the civil
20 commitment system through a set of complex regulations that
21 Oregon Health Authority is commandeering community hospital
22 beds.

23 THE COURT: Right. They're taking your beds, which
24 you've said is a property takings claim, right?

25 MR. NEIMAN: Right. The line between -- in the cases

1 between a physical taking and a regulatory taking is not always
2 clear.

3 THE COURT: Again, I'm aware of that. I'm only
4 asking what you've pled.

5 MR. NEIMAN: Well, we tried to allege, I think, both
6 a regulatory and a physical taking under the Fifth Amendment.

7 THE COURT: Did you brief a regulatory taking in
8 response to the motion to dismiss? Did you cite any regulatory
9 takings cases?

10 MR. NEIMAN: I believe we did, Your Honor.

11 THE COURT: All right. Thank you. I'll turn to your
12 opponent then on these substantive issues.

13 Anything you wish to add?

14 MS. SCOTT: Yes, Your Honor.

15 With respect to whether they briefed a regulatory
16 taking, we point out in our brief that they did not address the
17 three-factor test for a regulatory taking. They didn't
18 identify any distinct investment-backed expectations, let alone
19 describe to any degree the economic impact of the alleged state
20 conduct or the extent to which the conduct has interfered with
21 any distinct investment-backed expectations.

22 I would also add that with respect to whether the
23 takings claim rises and falls on the voluntariness issue, I
24 think it also falls on the relief they're seeking. They're not
25 seeking just compensation. They haven't asked the State for

1 additional money. They're seeking a widespread injunction
2 stopping the taking from happening in the first place, which
3 would -- takings law does generally not allow the injunction.
4 The remedy is compensation. And so I think that's another
5 reason why the taking claim fails.

6 THE COURT: Thank you very much.

7 MR. NEIMAN: We have found the place in our brief
8 where we spoke to the regulatory takings cases, Your Honor.
9 It's on pages 33 and 34.

10 THE COURT: And you walk through the three-part test?

11 MR. NEIMAN: No.

12 THE COURT: *Penn Central*?

13 MR. NEIMAN: No.

14 THE COURT: Thank you.

15 Let's talk about standing to bring the claim on
16 behalf of third parties. One issue is the same standing issue
17 we've already discussed, but there's a second issue, the sort
18 of close relation to a third party that's been developed in
19 case law as a correspondence of interest.

20 What's your argument on that?

21 MR. VAN RYSSELBERGHE: So, Your Honor, our argument
22 for the close relationship, so a close relationship as
23 discussed in the *Singleton v. Wulff* opinion from 1976, explains
24 that there's two aspects of that relationship. One is whether
25 the right of the third party is inextricably bound up with the

1 activity the litigant wishes to pursue. And I don't think
2 there's any dispute that that prong of the close relationship
3 test is met here.

4 Now, then there's a second prong of that test under
5 *Singleton*, which discusses whether the -- whether the
6 litigant -- here hospitals -- is as good as or nearly as good
7 as an advocate for the rights of the third party. And here
8 that is met -- so there's multiple ways to meet that prong, and
9 this is getting to the -- sort of what it means to be in an
10 alignment of interests here, a correspondence of interests.

11 So for one, the relationship between a health care
12 provider and a patient is such a relationship that is
13 confidential and fiduciary in nature, that under the case law
14 that has been deemed sufficient for a close relationship in
15 numerous cases involving doctors asserting claims of patients,
16 in addition to other entities like universities or vendors
17 asserting claims on behalf of students and customers. Now,
18 that's one way you can have a sufficient close relationship.
19 Another way is where you can -- even if there's not a
20 preexisting literal relationship between human beings, if you
21 have a situation where government conduct is equally or
22 simultaneously affecting two groups in mostly the same way,
23 then there's an alignment of interest there.

24 So, for instance, in the *Singleton v. Wulff* case, for
25 example, you had a Medicaid provision that removed Medicaid

1 funding for abortion services. That affected doctors because
2 they wouldn't get paid for those services and it affected
3 patients as well simultaneously because those patients were
4 foreclosed off from receiving certain care. And because those
5 alignments were -- those interests were aligned, there was a
6 close relationship.

7 Here it's a similar situation because OHA is failing
8 to ensure that patients in our hospitals get the long-term
9 treatment they need, and we can't provide any further acute
10 stabilizing care for them, but they can't move on until they
11 are -- have that long-term care provided for them. And as a
12 result of their -- of our inability to discharge them, that's
13 where our property deprivation comes into play. So the only
14 way to cure that property deprivation is for our patients to
15 have long-term treatment available to them either in the Oregon
16 State Hospital system or elsewhere, including in long-term
17 secure residential treatment facilities across Oregon.

18 So because the only way that our patients can
19 receive, you know, the only way that everybody can win is that
20 for our patients to receive the care to which they're
21 constitutionally entitled, and when that happens, then our
22 property deprivation will cease. So in that way, because all
23 of this comes from the same conduct by OHA, our interests are
24 aligned in the same way that doctors and patients are aligned
25 in, for instance, *Singleton v. Wulff* and other case law.

1 THE COURT: Your briefing, though, has described a
2 divergence, right? I mean, your briefing describes the
3 patients as a financial and other burden on your clients.

4 MR. VAN RYSSELBERGHE: So I would disagree that that
5 creates a divergence of interest here, because what matters is
6 not the fact that there's an ongoing property deprivation while
7 these patients are in our care and not able to receive or
8 benefit from our services. What matters is the relief we are
9 seeking, which is for the outcome of this lawsuit will result
10 in either both patients and hospitals gaining or not. There's
11 not a situation where there's a conflict insofar as hospitals
12 can gain where civilly committed patients do not gain or they
13 lose.

14 THE COURT: What if as a result of this lawsuit the
15 State says, dealing with the lawsuit by health systems is a
16 headache we don't need, so we will find another place for these
17 patients and we won't burden health systems with these patients
18 any longer, with that other place chosen by OHA isn't as good
19 as the hospitals. And your clients, I assume, would walk away
20 at this point, right?

21 MR. VAN RYSSELBERGHE: If OHA were to take that sort
22 of remarkable position --

23 THE COURT: It's not remarkable at all. They have
24 multiple options. You're the best option in their view right
25 now, so they don't like a lawsuit, so they pick a not as good

1 an option just to get you off their back. It happens every day
2 in litigation. Your clients would be satisfied, right? All
3 your clients' interests would be satisfied.

4 MR. VAN RYSSELBERGHE: In that situation --

5 THE COURT: It's really just a matter of saying your
6 clients' interests in this litigation are entirely satisfied if
7 these patients go away.

8 MR. VAN RYSSELBERGHE: Under the current regulatory
9 and statutory framework, I just don't think that it's possible,
10 because even if OHA was -- I think --

11 THE COURT: Something other than your clients has to
12 be possible because that's why you brought this lawsuit.

13 MR. VAN RYSSELBERGHE: The way out of this situation
14 is for there to be more services that are constitutionally
15 appropriate for our patients, and until that happens --

16 THE COURT: Believe me, I'm aware that that halcyon
17 day is the way out, but it's not going to happen tomorrow. And
18 so let's say the State says, well, we're not there yet nor will
19 we ever be there in the lifetime of care of some of these
20 patients, so we've got to do something else. It's just
21 straightforward, right? It's a hard question but a simple one.
22 Your clients' lawsuit has to be satisfied if somebody else
23 takes cares of these patients.

24 MR. VAN RYSSELBERGHE: That would -- our position is
25 that in order for somebody else to take care of these patients,

1 it has to be constitutionally adequate, and until that happens,
2 our interests are aligned. It's not enough to just say that
3 these issues can be fixed tomorrow. We don't -- we're not
4 contending that they can be. What is important is that their
5 rights are not being met, and it's not enough to simply say
6 funding is short or space is short. And so, by law, we cannot
7 simply allow for patients in our custody who we have medical
8 and legal duties to provide medical treatments and to do no
9 harm, we cannot simply allow for those patients to be sent
10 outside of our hospital if that would hurt them or would be bad
11 for them or against their medical interests.

12 THE COURT: What place, if any, does DRO play in this
13 analysis?

14 MR. VAN RYSSELBERGHE: So DRO certainly has the
15 authority to, under the PAIMI Act, to advocate for specific
16 groups that they choose to represent. But because in this
17 litigation, in the Mink-Bowman case and here in the -- in our
18 lawsuit, they have chosen to represent aid-and-assist patients
19 and expressly seek for those patients, aid-and-assist patients,
20 to be prioritized over civilly committed patients. That
21 precludes them from having -- from being proper advocates of
22 civilly committed patients here.

23 THE COURT: Thank you very much.

24 MR. VAN RYSSELBERGHE: Thank you.

25 THE COURT: Go ahead.

1 MS. SCOTT: Just a couple of responses.

2 The four cases that plaintiff's counsel cites for the
3 close relationship are doctor-patient relationships.

4 Plaintiffs -- hospitals are not in a doctor-patient
5 relationship with the patients whose rights they're asserting.

6 The case that we believe is on all fours with this
7 situation is *Siskiyou Hospital v. California Department of*
8 *Health Care Services*. It's almost an identical fact pattern.
9 And the Court there found there was not a close relationship
10 because they were two steps removed from the patient, between
11 the patient, the doctor, and the hospital. The case is fully
12 briefed in our motion to dismiss and reply and also in DRO's
13 amicus brief.

14 THE COURT: What about the idea that in this
15 litigation if health systems win, the patients sort of in pari
16 passu win to the same degree?

17 MS. SCOTT: I heard counsel saying that if the health
18 systems win, there's no current place for the patients to go.
19 So I don't see how they could win. We're not hearing from the
20 civilly committed patients about where they want to be right
21 now. There is, as Your Honor knows, a capacity challenge
22 throughout the state's behavioral system because there isn't a
23 voice for where these patients could go right now, and the
24 private hospitals, from their complaint and their brief, want
25 an injunction prohibiting OHA from placing them in the private

1 hospitals. Their interests are not aligned at this juncture.

2 THE COURT: Thank you very much.

3 MR. VAN RYSSELBERGHE: Reply, Your Honor?

4 THE COURT: Go ahead. Thank you.

5 MR. VAN RYSSELBERGHE: I want to clarify we are not
6 seeking an injunction here for patients not to be placed with
7 us. That's exactly the opposite of what we're looking for.
8 And this is actually a good way to discuss the *Siskiyou*
9 *Hospital* case, because in that case --

10 THE COURT: What are you seeking?

11 MR. VAN RYSSELBERGHE: We're seeking an injunction
12 for OHA to cease the -- its unconstitutional practices, which
13 includes requiring OHA to provide services, these long-term
14 service options in the community so that our patients can get
15 that treatment that they cannot get at our hospitals.

16 THE COURT: You want me to enjoin whom to do what?
17 Imagine that I'm signing a one-page document that tells
18 somebody to do something. What does it tell them to do?

19 MR. VAN RYSSELBERGHE: Well, so that gets into relief
20 questions that, you know, I think we're still at the early
21 stages of litigation, but in essence, we're seeking an
22 injunction for OHA to create these resources where they're
23 not -- they do not now exist. And so now I understand that
24 that can't happen overnight, and we don't contend it can, but
25 it still needs to happen. And that's the basis --

1 THE COURT: If I enjoined OHA with all deliberate
2 speed to build out new facilities, what relief would you be
3 seeking in the interim for your clients?

4 MR. VAN RYSSELBERGHE: You know, I think there would
5 be a lot of specifics to hash out that I'm not prepared to
6 commit to at this point, but we would have, you know,
7 discussions about -- we could litigate the specifics about sort
8 of what to do.

9 THE COURT: You act like this is a future question,
10 but it's a very important question for my analysis here today.
11 Are you seeking in the interim -- well, would you be taking the
12 position in the interim that you'd keep receiving these
13 patients until new facilities were built out, or would you be
14 asking that they be sent somewhere else?

15 MR. VAN RYSSELBERGHE: I believe we would keep taking
16 these patients, Your Honor. We're not asking for them to be
17 sent elsewhere.

18 THE COURT: Thank you.

19 Go ahead.

20 MR. STENSON: Good afternoon, Your Honor. I don't
21 think I have too much to add.

22 I do think that Your Honor has hit the nail on the
23 head in terms of the obvious conflict. We are currently
24 dealing with the realities of a system with limited resources,
25 and it's very likely in that system of limited resources that

1 any possible settlement between the Oregon Health Authority and
2 the hospital corporations, should this be allowed to proceed,
3 would balance in some way the speed of getting patients out of
4 the hospitals versus the quality of the places they've actually
5 been moving into. You know, if the -- I'm not saying this is
6 something OHA would necessarily do, but if OHA said, we want to
7 get rid of this immediately, we'll move people into homeless
8 shelters, they could do that really fast, but the quality of
9 services wouldn't be great. And between, you know, very poor,
10 nontherapeutic settings like homeless shelters and, you know,
11 really excellent residential, you know, services, either that
12 the clients would want and would benefit from, there's a whole
13 spectrum of possible outcomes. So if the hospital's vested
14 interest is getting patients out quickly, you know, in whatever
15 format, that's their individual interest and that doesn't align
16 with the interest of patients.

17 So I'm concerned that if they're permitted to stand
18 in the shoes of the patients, that that's a scenario that we'll
19 be entertaining in the future, that there will be some outcome,
20 some alternative placement which will balance strongly in favor
21 of getting people out quickly versus getting them to the
22 placement they need to be. That's the nature of a conflict of
23 interest, Your Honor.

24 In terms of the third-party standing questions, the
25 hospital corporations have indicated that there's some sort of

1 per se relationship because somebody has a doctor-patient
2 relationship, as in *Singleton*. But that's clearly not enough
3 standing on its own just to be a doctor and a patient or just
4 to be a healthcare corporation who is providing -- who is
5 paying the people who are providing services to a patient,
6 because doctors get sued by their patients all the time.
7 Providence or Legacy get sued by patients all the time. So
8 clearly their interests are not always aligned. And, in fact,
9 in the Supreme Court jurisprudence on this, the Supreme Court
10 has focused on the actual interests of the parties relative to
11 the case at bar, not simply to the proximity of the
12 relationship.

13 In *Newdow*, the Supreme Court said a father couldn't
14 have third-party standing to represent his daughter, and
15 there's no relationship in the law that's more privileged than
16 the relationship between a parent and a child. So clearly when
17 we're talking about third-party standing, we're talking not
18 just about is there a vendor-vendee relationship, is there a
19 doctor-patient relationship, is there an attorney-client
20 relationship, another relationship that the U.S. Supreme Court
21 has rejected for per se third-party standing. Clearly it's
22 whether the actual interests are aligned. And it really
23 radiates out from the briefing how much the relationship
24 between the healthcare corporations' interests are not aligned
25 with that of their patients.

1 So I think it's certainly part of the analysis to say
2 what's the nature of that relationship, but there is certainly
3 no per se close relationship simply because one is a healthcare
4 provider or a healthcare corporation and the third party is a
5 patient.

6 And in terms of what's being sought, I'm a bit
7 perplexed at this notion that no one before this Court has ever
8 asked for OHA to expand the realm of its offerings so that
9 patients don't have to live in restrictive settings, because
10 that's all that DRO and MPD have been doing for the last four
11 years is to ask this Court for relief that would expand the
12 availability of those resources.

13 THE COURT: Do you agree with the argument that
14 you're in a difficult position vis-a-vis civilly committed
15 patients by virtue of the relief you're seeking for
16 aid-and-assist?

17 MR. STENSON: I do not agree with that, Your Honor.
18 That is common to a wide variety of -- any time you have more
19 than one client, there are individual challenges, you know. So
20 we have challenges where, you know, if some patient has been in
21 for 40 days, another patient has been in for 12 days, both of
22 those patients want to get out. And so we have to set some
23 timeline that says we're going to prioritize people who have
24 been in longer. We have to have some concept and some
25 prioritization. The fact that there's some prioritization

1 doesn't create an actual conflict of interest. And, in fact,
2 any attorney who tries to represent a group of patients will
3 have challenges around exactly the mechanism of how, you know,
4 access to whatever the monetary or injunctive relief is, how
5 that's prioritized among the individuals in that group. So
6 that's not unique to DRO or to MPD or to any other
7 representative organization, and we have pressed for the
8 development of those resources, and if those resources are
9 developed, they will be available to people in civil
10 commitment, they'll be available to people who are on
11 aid-and-assist commitments, they'll be accessible to people who
12 are on GEI.

13 THE COURT: Thank you very much.

14 I want to turn to the motion for clarification on
15 intervention. A lot of it centers on things we've already
16 discussed, but there's also a timeliness question. So do you
17 wish to be heard further on the absence of meeting the
18 timeliness prong?

19 MR. STENSON: Your Honor, I would just say that, you
20 know, the issue at stake in terms of the prioritization, as has
21 been roundly attested to throughout the briefing, that's a
22 phenomenon that's been ongoing since 2019, and so it's unclear
23 why this should be considered a timely intervention to seek to
24 finally address this issue four years into the process. And I
25 would say, you know, the multiple cases that were cited show

1 that there's a strong disposition in the Ninth Circuit not to
2 allow this kind of waiting until some sort of settlement has
3 been struck, you know, staying out of that process, staying out
4 of the work of trying to engage in settlement, and then
5 complaining when somebody does, you know, resolve their
6 dispute. So I think in this case there was a clear opportunity
7 to intervene at any point in the last four years.

8 THE COURT: Thank you.

9 Do you wish to be heard on timeliness?

10 MR. NEIMAN: It is remarkable that -- now we're
11 talking about the Mink case?

12 THE COURT: Correct.

13 MR. NEIMAN: That case has been going on for 22
14 years, and the first time that anybody brought the impact of an
15 interconnected mental health system to the Court's attention
16 was in September of last year, in terms of representation and
17 giving a voice to civilly committed individuals. It wasn't
18 until September of last year that this Court entered its order,
19 and there was no effort to include -- by the parties to the
20 case to bring the State's community hospitals to the table. So
21 as soon as the order that the Court entered was issued, we were
22 in court intervening within a month. That, we think, speaks to
23 prompt action once there was something to act on.

24 THE COURT: Thank you.

25 Do you wish to reply?

1 MR. STENSON: I mean, the notion that it was
2 incumbent on either OHA or DRO or MPD to send an invitation to
3 the hospitals to participate is just absurd and without
4 foundation. It's clear in the Ninth Circuit case law that it
5 is incumbent on the party to vindicate their own interest, to
6 show up and to be vigilant in pursuing it, not to wait until an
7 order is entered and then oppose it. That's thoroughly
8 briefed. So the idea that there's some privilege to wait until
9 an order is entered, and only then act, is rebutted by
10 voluminous case law on this exact point.

11 THE COURT: Thank you all very much. I'll get you my
12 answer as soon as possible.

13 We'll be in recess.

14 THE COURTROOM DEPUTY: All rise. Court is in recess.

15 (Proceedings concluded at 2:28 p.m.)
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I certify, by signing below, that the foregoing is a correct transcript of the record of proceedings in the above-entitled cause. A transcript without an original signature or conformed signature is not certified.

/s/Bonita J. Shumway

April 28, 2023

BONITA J. SHUMWAY, CSR, RMR, CRR
Official Court Reporter

DATE

<p>MR. JOHNSON: [1] 4/13 MR. MERRITHEW: [1] 4/11 MR. NEIMAN: [55] 4/19 24/10 24/14 24/16 25/22 26/2 26/8 26/13 26/18 26/23 27/5 27/9 27/13 27/23 28/5 28/13 32/20 33/8 33/22 33/24 34/1 34/6 34/10 34/12 34/22 35/4 35/18 35/20 36/1 36/9 36/11 36/20 37/7 37/13 37/19 37/22 38/4 38/18 38/21 39/3 39/13 40/1 40/4 40/8 40/12 40/16 40/19 40/25 41/5 41/10 42/7 42/11 42/13 55/10 55/13 MR. STENSON: [5] 4/9 50/20 53/17 54/19 56/1 MR. VAN RYSSELBERGHE: [57] 4/17 9/21 9/23 10/16 11/6 11/10 11/15 11/22 12/1 12/7 12/16 12/21 12/23 13/25 14/8 14/12 14/15 16/10 16/13 16/16 17/5 17/8 17/10 17/16 17/22 18/4 19/5 19/7 19/10 20/13 20/24 21/2 21/8 21/23 22/1 22/4 22/8 22/23 23/6 23/13 23/20 24/2 42/21 45/4 45/21 46/4 46/8 46/13 46/24 47/14 47/24 49/3 49/5 49/11 49/19 50/4 50/15 MS. SCOTT: [21] 4/15 14/17 15/14 15/19 16/3 16/5 28/17 29/4 29/9 29/17 30/3 30/6 30/15 31/2 31/6 31/18 32/6 32/17 41/14 48/1 48/17 THE COURT: [136] THE COURTROOM DEPUTY: [2] 4/4 56/14</p>	<p>301 [1] 3/4 309-033-0420 [1] 15/1 326-8188 [1] 3/5 33 [1] 42/9 333-505-0055 [1] 19/1 34 [1] 42/9 3:02-cv-00339-MO [1] 1/4 3:02-cv-339-MO [1] 4/5 3:21-cv-01637-MO [1] 1/9 3:21-cv-1637-MO [1] 4/6</p>	<p>acknowledge [1] 5/24 across [5] 7/23 10/1 10/2 25/7 44/17 act [4] 47/15 50/9 55/23 56/9 action [6] 6/12 6/15 6/18 28/25 39/17 55/23 actions [1] 22/17 activity [1] 43/1 actual [3] 52/10 52/22 54/1 actually [4] 38/25 40/4 49/8 51/4 acute [35] 10/19 11/16 11/18 11/19 11/24 12/6 12/8 12/9 12/17 12/24 12/25 13/2 13/3 13/12 16/22 18/6 18/6 18/24 20/1 20/1 23/8 23/15 23/20 23/23 23/25 30/11 31/10 32/1 34/24 34/25 36/2 36/6 37/8 38/5 44/9 add [3] 41/13 41/22 50/21 addition [3] 15/24 18/25 43/16 additional [4] 15/5 15/6 16/1 42/1 address [4] 18/18 18/20 41/16 54/24 addressed [1] 24/11 adequate [2] 8/24 47/1 administrative [6] 14/21 26/25 30/20 32/21 35/8 40/9 admission [1] 31/7 admissions [1] 10/7 admit [5] 15/22 17/19 29/20 31/4 31/4 admitted [1] 32/25 advance [1] 8/21 advancing [1] 8/9 ADVOCACY [2] 1/3 4/5 advocate [2] 43/7 47/15 advocates [1] 47/21 affected [2] 44/1 44/2 affecting [1] 43/22 after [5] 5/4 14/2 24/11 27/14 33/12 afternoon [1] 50/20 again [11] 6/21 7/6 7/18 8/10 8/24 9/3 9/18 17/25 20/24 22/24 41/3 against [1] 47/11 ago [3] 23/11 37/15 38/24 agree [6] 5/10 29/16 29/17 39/18 53/13 53/17 agreed [2] 12/4 13/7 agreement [1] 10/9 ahead [6] 12/22 20/22 24/13 47/25 49/4 50/19 aid [4] 47/18 47/19 53/16 54/11 al [7] 1/3 1/6 1/8 1/11 1/13 4/6 4/6 Alder [1] 2/9 Alex [2] 2/15 4/17 align [1] 51/15 aligned [8] 44/5 44/24 44/24 47/2 49/1 52/8 52/22 52/24 alignment [2] 43/10 43/23 alignments [1] 44/5 all [31] 8/23 9/16 16/8 16/16 16/18 21/4 21/7 23/19 24/14 24/16 26/6 27/2 28/4 29/23 30/22 31/18 32/19 36/9 39/14 40/17 41/11 44/22 45/23 46/2 48/6 50/1 52/6 52/7 53/10 56/11 56/14 allegation [2] 15/14 15/16 allegations [2] 11/1 15/4 allege [5] 10/5 12/25 14/17 20/14 41/5 alleged [5] 13/17 28/24 35/17 38/17 41/19</p>
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